INDIANA DEPARTMENT OF CHILD SERVICES	**INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE MANUAL**	
	Chapter 8: Out-of-Home Services	**Effective Date:** June 1, 2008
	Section 30: Psychotropic Medication	**Version:** 1

POLICY: **OLD POLICY: N/A**

The Indiana Department of Child Services (DCS) will require that informed consent be obtained from the parent/guardian/custodian and from the appropriate DCS Local Office Director or his/her designee before a child in out-of home care is placed on psychotropic medication.

Exception: DCS will waive the requirement to obtain parental consent, if:

1. The parent/guardian/custodian cannot be located, or
2. Parental rights have been terminated, or
3. The parent/guardian/custodian is unable to make a decision due to physical or mental impairment; or
4. Prior court authorization has been obtained.

If the parent/guardian/custodian denies consent:

1. A Child and Family Team must be convened immediately to determine if DCS will seek a court order for authorization of the recommended medication. See separate policy, 5.7 Child and Family Team Meetings.

Medication can be administered without prior consent if it is needed to address an emergency condition in which the child is a danger to himself/herself or others, and no other form of intervention will mitigate the danger. Consent must be obtained within 24 hours of administering the initial dose of medication on the weekends or holidays.

DCS has the right to request a second opinion, if there are questions surrounding the need for and/or use of psychotropic medication.

Code References
IC 16-36-1: Health Care Consent

PROCEDURE

The Family Case Manager (FCM) will:

1. Engage the Child and Family Team (CFT) regarding the physician's recommendation for psychotropic medication and develop a plan for ensuring the child's mental health needs are met. See separate policy, 5.7 Child and Family Team Meetings.
2. Review the Authorization for Psychotropic Medication form with the parent/guardian/custodian and the CFT. See separate policy, 5.7 Child and Family Team Meetings.
3. Obtain the parent/guardian/custodian's signature on section B of the authorization form. If the parent/guardian/custodian denies consent, seek a court order if it is in the best interest of the child.

4. Submit the Authorization for Psychotropic Medication form to the DCS Local Office Director or his/her designee.
5. Seek a second opinion from another physician or child psychiatrist for any recommendations that involve:
   a. Prescriptions for five (5) or more psychotropic medications.
   b. Prescription of an antidepressant to a child less that four (4) years of age.
   c. Prescription of an antipsychotic medication to a child less than four (4) years of age.
   d. Prescription of a psycho stimulant to a child less than three (3) years of age.

6. Notify the requesting physician whether the authorization has been granted and if any further action will be needed.
7. Provide the requesting physician and the parent/guardian/custodian with copies of the Authorization for Psychotropic Medication form once it has been completed (fax is acceptable).
8. Ensure that the resource family is aware of the purpose of the medication, the expected responses to the medication including any possible side effects.
9. Ensure that the prescription is filled.
10. Place the original signed form in the child's case file.

The FCM will direct the prescribing physician to:

1. Complete section A of the Authorization for Psychotropic Medication form.
2. Submit the form to the assigned FCM for the child.
3. Contact DCS within 24 hours of administering the initial dose of medication if a child is placed on psychotropic medication due to an emergency condition.

The DCS Local Office Director or designee will:

1. Review all requests and complete section C of the Authorization for Psychotropic Medication form within one (1) business day of receiving the form from the FCM.
2. Return the signed form to the FCM.

PRACTICE GUIDANCE

N/A

FORMS AND TOOLS

NEW – Authorization for Psychotropic Medication (Not yet available)

RELATED INFORMATION

Informed Consent

"Informed Consent" as defined in Indiana Code 16-41-6-2 means authorization for a physical examination, made without undue inducement or any form of force, fraud, constraint, deceit, duress, or coercion after the following:

1. A fair explanation of the examination, including the purpose, potential uses, limitations, and the fair meaning of the examination results;
2. A fair explanation of the procedures to be followed, including the following:
   a. The voluntary nature of the examination.
   b. The right to withdraw consent to the examination process at any time.
   c. The right to anonymity to the extent provided by law with respect to participation in the examination and disclosure of examination results.

Psychotropic Medications

Psychotropic medications are those prescription drugs used to control and/or stabilize mood, mental status, behavior or mental health. Psychotropic medicines generally fall into one of the following categories:

1. Antidepressant/Antianxiety, e.g., Prozac, Zoloft, Paxil;
2. Antipsychotic, e.g., Haldol, Risperdal, Zyprexa;
3. Psychostimulants, e.g., Ritalin, Adderall; and
4. Mood Stabilizers, e.g., Lithium.

Discussing Psychotropic Meds at Family Team Meeting

The FCM should use the completed Authorization for Psychotropic Medication form to focus the discussion at the meeting. In particular, the option of alternative therapies and behavioral approaches should be explored before psychotropic medication is considered. Additionally, the family may wish to invite the child's physician/psychiatrist to attend the meeting.

Requests that Require Increased Review

There are certain circumstances that require additional consideration and review, including, but not limited to:

1. Prescription of five (5) or more different psychotropic medications.
2. Prescription of an antidepressant to a child less than four (4) years of age.
3. Prescription of an antipsychotic to a child less than four (4) years of age.
4. Prescription of a psychostimulant to a child less than three (3) years of age.

Medications at the Time of Removal

If a child is on psychotropic medication at the time of removal, the medication, potential side effects and any concerns should be addressed with the child's primary care physician.

Indiana Department of Child Services
Authorization for Psychotropic Medication

In accordance with DCS policy, consent must be obtained from the child's parent/guardian/custodian and from DCS prior to giving any child in out-of-home care psychotropic medication. See the DCS Psychotropic Medication policy for exceptions.

PART A: (To be completed by the physician prescribing the medication)

Name of Physician: Insert Text Here **Physician's Contact Number:** Insert Text Here

Name of Child: Insert Text Here **Child's Date of Birth:** MM/DD/YYYY

Diagnosis: **Date of Diagnosis:** MM/DD/YYYY

Was the child given unauthorized medications due to an emergency?
☐ **Yes** ☐ **No**

If yes, please explain the situation below and list all medications given to the child, as well all other intervention that was attempted.
Insert Text Here

Recommended Medications:

Medication	Dosage	Targeted Symptoms	Duration

Side Affects & Adverse Reactions
Please attach a list of all potential side affects and/or adverse reactions for each medication listed above.
Are there any potentially irreversible side effects? ☐ YES ☐ NO
If yes, please explain in detail. Insert Text Here

Blood Draws
Will routine blood draws be needed while the child is on this medication? ☐ YES ☐ NO
If yes, please explain in detail. Insert Text Here

Interaction with other Medications
Please explain how the medications listed above will interact with other medications the child takes. Insert Text Here

Alternate Treatment Options
Please explain what alternate treatment options are available. Insert Text Here

Continued on next page

Additional Treatment
Please explain what additional treatment will be used, i.e. individual counseling, group therapy, etc. Insert Text Here

By signing below, I certify that the above information is true to the best of my knowledge.

_____ _____
Signature of Physician Date

PART B: (To be completed by the child's parent/guardian/custodian)

SELECT ONE

☐ By signing below, I give my consent for Insert Child's Name to take the medication(s) listed above as recommended by his/her physician.

_____ MM/DD/YYYY
Signature of Parent/Guardian/Custodian Date

☐ By signing below, I do **not** give my consent for Insert Child's Name taking the medication(s) listed above as recommended by his/her physician.

_____ MM/DD/YYYY
Signature of Parent/Guardian/Custodian Date

PART C: (To be completed by the DCS Local Director or Designee)

SELECT ALL THAT APPLY

☐ By signing below, I give my consent for Insert Child's Name to take the medication(s) listed above as recommended by his/her physician.

☐ By signing below, I waive **the requirement to obtain consent from the child's parent/guardian/custodian because:**
- ☐ A court order has been issued authorizing the medication;
- ☐ The parent/guardian/custodian cannot be located;
- ☐ Parental rights have been terminated;
- ☐ The parent/guardian/custodian is unable to make a decision due physical or mental incapacitation.

☐ By signing below, I do **not** give my consent for Insert Child's Name taking the medication(s) listed above as recommended by his/her physician.

_____ MM/DD/YYYY
Signature of local DCS Office Director Date

_____ (___)___-____
County & DCS Region Contact Number